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ABSTRACT

This paper discusses the importance of preventive intervention in maintaining the mental health of children. Definitions of prevention are presented, with particular focus on primary prevention, i.e., the lowering of the rate of emotional disorders in a population. The importance of focusing on prevention in childhood is emphasized, and the potential for prevention and intervention in schools, by teachers and school psychologists, is discussed. Two major areas of primary prevention, general health promotion and protection against specific disorders, are examined in detail. Subdivisions of health promotion are discussed including: competence building, which involves teaching children problem-solving and social skills and teaching teachers attitudes that will enable them to improve relationships with students; and intervention in the psychosociocultural context involving specific interventions in school and the community. The two areas of specific protection, screening (a process for identifying children at risk), and crisis intervention, are delineated. Obstacles to instituting a primary prevention program in schools are discussed and implications for school psychologists regarding primary prevention or the lack of it in the schools are highlighted. Notes and references are included. Appendix A contains a diagram representing the different levels and subdivisions of primary prevention. (BH)

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PRIMARY PREVENTION, SCHOOLS AND THE
SCHOOL PSYCHOLOGIST

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Traditional folk wisdom often trumpets the importance of prevention. Intuitively, sayings like "An ounce of prevention is worth a pound of cure" and "A stitch in time saves nine" do make sense. Despite this the mental health professions have generally ignored this "wisdom" until relatively recently (Meyers, 1977). Rather, they have chosen to focus on the diagnosis and treatment of those already in need.

In the last twenty years, however, the mental health professions have come to recognize the importance of preventive intervention. This has happened because professionals have increasingly realized that treatment alone can never fully deal with something as widespread as psychopathology (Caplan, 1964; Roberts, 1968). There is neither enough time nor enough trained personnel to serve all those in need via the diagnosis and treatment, or medical, model and we therefore end up ignoring a significant portion of those in need (Okin, 1977). Furthermore, there is evidence that many people who do experience emotional difficulty never turn to mental health professionals for help (Cowen, 1982).

Beyond that, however, there are positive reasons for engaging in preventive activities. Primary prevention implies the responsibility of the mental health professional for trying to meet the mental health needs of the entire population, and not just for those of the "casualties" of life's experience (Goldston, 1977). Also, it forces one to provide

service before there is a full blown problem (Roberts,1968). As such,prevention stands for positive mental health(Jahoda, 1958) as opposed to curing disease.

Before discussing this issue further,the term "primary prevention" itself must be more fully defined. "Primary prevention" stems from Caplan's (1964) division of mental health work into into a three pronged preventive system which consists of primary, secondary and tertiary prevention. Although,there are many different definitions of the three terms in the literature (Cowen,1977;Lemle,1976), there is some basic agreement as to their abstract meanings (Cowen,1977). Primary prevention refers to the lowering of the rate of emotional disorders in a population (Caplan,1963;1964;Clarizio,1979; Roberts,1968) and covers those measures that will achieve this goal (Roberts,1968). Secondary prevention refers to the early diagnosis and treatment of those in need (e.g.,Caplan,1964), and the limitation of their disability (Bower,1977;Chalke & Day,1968;Clarizio,1979). Tertiary prevention refers to the rehabilitation of those with established disabilities (Chalke & Day,1968).

As is evidenced by the preceding discussion, Caplan's (1964) reference to any action a mental health professional takes- even rehabilitation of entrenched disorders- as "prevention" has led to some confusion and murkiness about what is preventive about mental health prevention. Would that we could, as Wagenfeld (1972) laments,turn back the clock and use the pre-Caplanian terminology of prevention, treatment,

and rehabilitation. Alas, we can not and this paper will therefore refer only to primary prevention when it refers to prevention.

Though not all authors in the field would agree with the following, an exposition of what constitutes primary preventive intervention that is culled from the relevant literature is presented. Since the targets of primary preventive activity are people who are presently asymptomatic or healthy (Clarizio, 1979; Goldston, 1977), many programs which label themselves "primary preventative" are in reality not so (Cowen, 1977). True primary prevention can be broken down into two basic areas-general health promotion and protection against specific disorders (Bower, 1977; Chalke & Day, 1968; Goldston, 1977; Lamb & Zusman, 1979). Each of these can be divided and further subdivided and these subdivisions will be discussed later in a practical sense.

General health promotion consists of competence building, or the building of psychological resources and health in people (Clarizio, 1979; White, 1979), as well as of interventions in the psychosociocultural context of behavior (Clarizio, 1979; Cowen, 1977; Levine & Perkins, 1980). Specific protection consists of identifying people at high risk for specific disorders (Bower, 1977) as well as of crisis intervention (Beiser, 1968; Roberts, 1968).

Most primary preventive work focuses on children (Caplan, 1964; Lapidus, 1977; Roberts, 1968). Whether or not one accepts the notion of psychic determinism, i.e., that adult

psychopathology is rooted in childhood experience, primary prevention in childhood ~~in~~ childhood makes sense (Guerney, 1979). If one accepts that notion, the reason ~~early~~ preventive intervention is needed ~~is~~ clear. Even if one does not, primary prevention is beneficial because it aims to provide children with skills to help them through crises which are potentially damaging to their functioning and thereby eases their development (Guerney, 1979).

Given the focus of prevention on intervening in childhood, the school becomes a crucial venue for such intervention. At a basic, logistical level, schools are important to primary prevention because of the access they give the mental health professional to most of the children in a community (Clarizio, 1979; Griffin, 1968; Okin, 1977). Where else can one find so many youngsters gathered five days per week, six hours per day, over so many years?

Besides its hold on, what Okin (1977) calls, a "captive audience," the school's meaning to the child and community and some of its organizational qualities add to its attractiveness as a site for promoting health and providing specific protection. School is one of the community's primary agents of socialization (Bower, 1977; Caplan, 1963; Rickel, et al, 1979; Zimilies, 1967) and determines to a large extent how a child perceives his world and himself (Caplan, 1963). Schools influence a child's sense of competence (Lemle, 1976; Rickel, et al, 1979; White, 1979), autonomy, trust (Lemle, 1976),

interpersonal relationships (Caplan,1963;Lemle,1976), (1967) values and attitudes (Lemle,1976). In fact, Zimilies goes so far as to say that at every moment a child is in school emotional and social development is occuring.

The meaning of the school to the child is especially important in kindergarten and the early grades because then it becomes an extension of the family (Caplan,1963) and tends to induce strong transferential ties to teachers (Caplan, 1963; Okin,1977). A s such, it can supplement, and overcome the effects of, inadequate experience and insufficient emotional supplies provided at home (Caplan,1963;Hunt,1961). In adolescence, when the peer group becomes to the adolescent's development (Erikson,1959), most often it is the school that provides this peer group (Caplan,1963;Lemle,1976). In fact, many of the child's important, often stress inducing , transisitions occur while she is in school: the transition from home to community; from voluntary (play) to obligatory (study) behavior; from child to adolescent; and from adolescent to young adult (Christozov et al,1976). Furthermore, as Clarizio (1979) points out, the school has the community sanctioned right to "interfere in someone elses business insofar as it relates to the child's educability(!), not only his education; From the perspective of the child's and community's needs, then, school offers many opportunities, indeed opportunities we dare not pass up, to assess and promote positive mental health, intervene in times of stress

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and identify children at risk and provide prophylactic intervention for them.

Some organizational characteristics of schools make it a prime target for primary preventive efforts. Schools are staffed by professionals who, at least in theory, are open to learning, collaboration and supervision and who have the stated goals of meeting, in the best possible way, the child's cognitive and emotional growth needs (Griffin, 1968).

That is not to say, of course, that there are not obstacles to implementing primary preventive programs in schools. Many of these will be discussed later. First, however, it is time to introduce an important actor in the drama of primary prevention in the schools-the school psychologist- and describe her role.

Since preventive intervention early in life is preferred (Caplan, 1963; 1964; Lapidus, 1977; Roberts, 1968) and since most children will not be seen in relation to other children until they enter some educational institution (e.g. day care, nursery), the first professionals the child comes in contact with will usually be the teacher and school psychologist. The school psychologist's training gives (or should give) her knowledge and expertise in the areas of the child's emotional, social and cognitive development.³ She is, therefore, particularly suited to provide for the child's mental health needs in an educational setting. This joint educational and psychological focus, and his place within the school, enables the school psychologist to enter preventive work with expertise and helps him, as Lapidus (1977) says, "provide

solutions for real children in real settings as they really are."(p. 185) This is not to say that only the school psychologist is well-suited for school-based primary prevention. Clarizio (1979) and Munger (1979) both speak of the dangers and futility of trying to "own" an approach. It does, however, indicate strongly that school psychologists should be viewing primary prevention as an integral segment of their professional responsibilities.

There are many techniques and programs available to the school psychologist interested in primary prevention. Even though many, if not most, of them have not been developed by school psychologists *per se* (a glaring professional lack!) they have been designed and implemented by psychologists, educators, social workers and psychiatrists,

working in the schools, and provide the school psychologist with an impressive repertoire of alternative strategies.

What follows is an exposition of the types of interventions possible in a school setting. Discussion of specific programs mentioned will, for the most part, be avoided due to the sheer volume of programs available and the space limitations of this paper. A graphic representation of the following can be found in Appendix A.

HEALTH PROMOTION: Competence Building

White (1979) underscores the crucial nature of competence building in children in concluding that being able to

competently affect one's environment is crucial to both intellectual and social development. Competence building in schools is of two types-interventions with children and interventions with teachers.

Interventions with children consist of teaching courses in behavioral sciences and teaching specific skills to help children deal with problems as they arise. Roen (1967) provides a three part rationale for teaching behavioral science curricula in the primary and high schools. By teaching behavioral science, emotional disorder is prevented by fortifying the child's ego - through the accumulation of knowledge and the learning of the language to label their subjectively felt tensions and discomforts; by leading to greater comfort in school - through learning about the learning process itself; and by spreading the effect in the community and thereby making it a more supportive and healthy environment. Examples of behavioral science curricula can be found in articles by Long (1970), Stone et al (1975) and Roen (1967).

The idea that teaching children specific social skills can help lower their future rate of psychopathology has led to a plethora of programs in the literature. These are all based on four underlying assumptions (Cowen, 1977): That there are identifiable core skills underlying sound adjustment; that curricula can be developed to teach these skills; that acquisition of competence in these skills will lead to better adjustment; and that gains in adjustment will endure. Leple

(1976) believes that the last two of these assumptions have not been satisfactorily proven. Others (e.g., Cowen, 1977; Goldston, 1979; Guerney, 1979), however, have examined the literature and have found it promising.

There are various curricular areas of training in social skills which have been tried in schools. Perhaps the most prevalent among these is that of social problem solving (see, for example, D'Zurilla & Goldfried, 1971; Hartman, 1978; 1979; McClure, Chinsky & Larcen, 1978; Spivack & Shure, 1974; Weisberg et al, 1981; among others). For reviews of these programs see Cartledge & Milburn (1980), Gesten et al (1979) or Urbain and Kendall (1980). Basically, they all teach stages in the problem solving process as a separate course unit and see skill in social problem solving as a basic tenet of healthy adjustment.

Other areas of social skills taught in schools stem from research on skills related to good adjustment. These include training in goal setting (Stamps, cited in Cowen, 1977), training for children's curiosity and questioning (Blank & Covington, 1965; Gall, 1971), training in interpersonal relationships (Chiasso, 1976; Guerney, 1979), and affective education (see, for example, Journal of Child Clinical Psychology).

In addition to intervening with children some authors have stressed the need to intervene with teachers (Ojemann, 1967; Roen, 1967; Zimilies, 1967). Ojemann (1967) favors incorporating psychological concepts into regular course

curricula. That is, he teaches teachers to seize on a moment and use and model what he labels "causal thinking." This type of thinking is described by Roen (1967) as encompassing an "...understanding and appreciation of the dynamic, complex and interacting nature of forces that operate in human behavior,.....an attitude of flexibility, of seeing things from the viewpoint of others and an awareness of the probabilistic nature of knowledge." (p.254). Research has shown this approach effective in leading to more secure (Griffin, 1968) and less punitive relationships (Roen, 1967) between children.

HEALTH PROMOTION: Intervention in the Psychosociocultural Context

The second major subheading of Health promotion implies intervention in the school and community environments. School and classroom environments do affect the behavior of children and adults within them (Insel & Moos, 1974; Sarason, 1971; Stallings, 1975; Trickett & Moos, 1974) and communities do impact on schools and children (Bower, 1977). The literature on this methodology of intervention is that of mental health consultation and is too vast to be reviewed here. For a brief, cogent overview of mental health consultation in the schools see Yammer (Note 1).

There are under this umbrella different types of interventions the school psychologist can look towards—always keeping in mind that one can not look at the effect of the environment independent of the people it is affecting. The crucial variable here is person/environment fit (Cowen, 1977; Levine & Perkins, 1980).

The school psychologist can intervene in the school's physical environment or in its psychological environment. Physical interventions include consultation around technological innovations-e.g., seating plans, colors, etc. For some case studies of intervention of this type see Ryan (1974) or Weinstein (1977).

Interventions in the school's psychological context can have the teacher (e.g., Caplan, 1970), the classroom or teacher group (e.g., Newman, 1974), or the entire system as the unit of analysis. It can focus on mental health issues from a case, staff or organizational viewpoint (Caplan, 1970).

Interventions in the community include intervening with parents and involvement in community organizing or political advocacy. Preventive intervention with parents is especially important and useful in the preschool and kindergarten years due to the overriding influence of the family at that age (Bowers, 1977; Lapidus, 1977). However, throughout a child's school career providing parents with an understanding of child development, an insight into individual differences and into the child's need for a supportive environment can be a crucial element of a preventive program (Lapidus, 1977; Roberts, 1968).

The school psychologist's concern with the mental health needs of his constituency need not stop at the door of his school. Since social conditions affect mental health (Hollingshead & Redlich, 1963; Leighton et al, 1963; Vance, 1977), primary prevention must include a community action component. This

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aspect will push the school psychologist intent on primary prevention in the direction of professionals in the policy sciences (Beiser, 1968). As Lapidus (1977) says, the prevention oriented school psychologist should be concerned with mobilizing community resources to meet the needs of children outside of school as well as in it.

SPECIFIC PROTECTION: Screening

The second major category of primary prevention is specific protection. Since the exact causes of emotional difficulties are fuzzy, less work has been done in this area. The types of interventions are screening for and intervention with children at high risk as well as crisis intervention.

Many people object to the use of screening for children at risk precisely because the exact etiologies of psychopathological entities are not clear (Lamb & Zusman, 1979). This, however, is based on a misunderstanding of the purpose of screening. Screening is done for the purposes of predicting which children will be most likely to experience emotional difficulty and not for the purpose of explaining why these children are at greater risk. As Kerlinger and Pedhazur (1973) convincingly explain, one need not have a strong theoretical basis to explain why this prediction works in order to use the screening procedure as a predictor. From a research design perspective, then, screening is a valid primary preventive tool.

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Practically, however, screening alone is relatively meaningless. Identifying children at risk can serve little purpose unless it is accompanied by intervention programs (Bower, 1977). Primary prevention programs have been instituted for risk of drug abuse (Stokely, 1978), child abuse (Broadhurst, (1977) and psychopathology (Rolf & Hasazi, 1977).

Bower (1977) presents an interesting perspective on screening. He screens entering kindergarten children not to identify cases, but to find positive connections between the parents' wishes, expectations, etc. and what the school can offer. He does this in order to find bases upon which to build school success. He is therefore screening for the all-important "child/school fit" spoken of by Cowen (1977) and Levine (& Perkins, 1980).

SPECIFIC PROTECTION: Crisis Intervention

Caplan (1963) describes the school psychologist's role in crisis intervention. The first step is the identification of a crisis. These are of two types: regularly occurring biopsychosocial crises; and accidental happenings. Biopsychosocial crises occur regularly at transition points in the child's development. These include stages of development as suggested by Freud, Piaget and Erikson, or those such as suggested earlier by Christozov (1976). Accidental happenings include family problems, the child's physical illness, and loss of significant others in school. The school psychologist must be alert to these and intervene accordingly. In this light Bower's (1977)

screening program is a crisis intervention program of the first type. An example of a program of the second type is that of Nelson, Peterson and Sartore (1975) on helping children deal with death.

The various divisions and subdivisions and subsubdivisions of primary preventive activity in the schools have been presented. There are, however, many obstacles to instituting a primary prevention program in the schools. Some of these are inherent in the approach, others are due to characteristics of schools.

Generally, obstacles to primary prevention center around three issues: the feeling that too many factors affect psychological functioning to make primary prevention feasible (Clarizio, 1979; Lamb & Zusman, 1979); the attachment to the traditional model of diagnosis and treatment-especially by those who pay the bills (Clarizio, 1979; Okin, 1977); and the difficulty in operationalizing primary preventive definitions and goals (Clarizio, 1979; Cowen, 1977; Goldston, 1977; Lamb & Zusman, 1979) which leads to claims of infrequent quality evaluation research (Lemle, 1976). There is, of course, disagreement on these issues which is why primary prevention continues to exist.

There are also properties inherent in schools which will cause the school psychologist interested in primary prevention to meet some resistance. ~~The~~ Positive mental health may be our goal but it is not the overriding goal of the educational system and the school psychologist will often have to yield psychological goals for some others-e.g., mastery

of subject matter (Caplan, 1963). Furthermore, in the population served by the school psychologist there are those in need of secondary and tertiary services. Public Law 94-142 reinforces the need to serve this segment of the school population and more fully focuses pressure on school psychologists to be involved in diagnostic and treatment modalities. Finally, as is noted by almost every writer on school consultation, schools are difficult institutions to change. In fact there are qualities of schools which work against positive mental health. Often schools reward teachers for seniority not merit, reward all for conformity not innovation and reward control rather than growth (Griffin, 1968). They are often more influenced by political and economic realities than by educational or psychological needs (Clarizio, 1979).

This is not presented to cause despair. The consultation literature is full of examples of how to work with or around the resistance to change found in schools. However, woe is to the school psychologist who naively expects his proposals for a primary prevention program to be listened to just because it makes sense. We must expect the resistance because it will be there,

What does all this mean to the school psychologist? The preceding discussions do have various implications for the school psychologist as a practitioner and as a scientist. As a practitioner the school psychologist must realize the constraints of his role as provider to a school's entire population and the limited public and political (and therefore monetary) commitment to primary prevention (Vance, 1977)

and provide for himself realistic guidelines for establishing his priorities among types of prevention, various techniques within each type and various problems with which he is presented. He must guard against becoming a "tester" and try to develop his role as "preventor" over time (see for example, Carner, in press; Clarizio, 1979). Further, the school psychologist can't let the vastness of primary prevention overwhelm him (Clarizio, 1979). There is too much to do alone and the approach to primary prevention must be collaborative (Clarizio, 1979; Monger, 1979), especially with those in regular education (Clarizio, 1979). When one decides on what to do he must set realistic goals based on what is known about prevention (Clarizio, 1979). Finally, the practitioner must be an informed consumer of scientific research. As Pedhazur (1982) points out many studies upon which important public policy and educational decisions will be based are not worth the paper they are printed on. Before one decides on an intervention strategy one must see whether it is based on sound research. Then of course the practitioner must evaluate how its implementation will affect and effected by his setting.

As a scientist, the school psychologist interested in prevention must, as Caplan (1963) states, measure the effects of the types of situations which recur in schools and attempt to identify the characteristics of those children in whom these situations provoke crises. There is a need for prospective

longitudinal studies to identify the coping patterns of those children who avert crises (Caplan, 1963; Goldston, 1979). The assessment of social environments must be explored and learned to identify the dimensions of their impact as well as to establish the connections between environmental qualities and personal development (Cowen, 1977). Finally, sound evaluation of interventions is crucial to the validity of the primary preventive approach (Caplan, 1963; Lemle, 1976).

Griffin (1968) laments that "If we only knew enough about the many genetic, constitutional, and environmental factors influencing personality development, and if these factors were subject to control, it would be possible to prevent the onset of mental illness"(pg. 152).

Perhaps with strong professional and scientific commitment to primary prevention, we can move towards this goal.

NOTES

Note 1. Yammer, D. Three approaches to mental health consultation in the schools: A synthesis. Paper presented at the meeting of the New York State Psychological Association, New York City, April, 1982.

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APPENDIX A

